Location _____
Date _____
New/Recert _____

CSFP APPLICATION FOR USDA COMMODITIES

Do not complete this application if your household has applied for or received CSFP benefits at another distribution site.

Nevada Department of Agriculture

Name of Applicant: _____
Last First MI

Address: _____
Street City State Zip Code

Home Phone No.: _____ Other Phone No: _____

Household Members

Name	Sex	Date of Birth	Age	CSFP Eligible
1.				
2.				
3.				

Race and Ethnicity

This information is voluntary. If you do not provide this information, it will not affect your eligibility.

What is your ethnic category? (Please mark one) ☐ Hispanic or Latino *or* ☐ Not Hispanic or Latino

What is your race? (Select all that apply) ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian

Household Income

CSFP Income eligibility requires the applicant to self-certify the household's gross income. Proof of income, such as bank statements, checks, or other documentation that might have personal information will not be collected, copied or stored in the applicant's file.

The total number of people living in my household is_____. Gross Income cannot exceed_____monthly/yearly.
(Agency completes)

I, the undersigned, certify that my household's current monthly/yearly gross income does not exceed the above listed amount. _____
Initials

Authorized Representative Other Than Self To Pick Up USDA Food

Name: _____ Phone Number: _____

Address: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027) found online at https://www.ascr.usda.gov/filing-program-discrimination-compliant-usda-customer and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: **program.intake@usda.gov**.

This institution is an equal opportunity provider.

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS APPLICATION :

This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes. I am also aware that I may not receive both CSFP and WIC benefits simultaneously, and I may not receive CSFP benefits at more than one CSFP site at the same time. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation. I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

I authorize the release of information provided on this application form to other organizations administering assistance programs for use in determining my eligibility for participation in other public assistance programs and for program outreach purposes. (Please indicate decision by placing a checkmark in the appropriate box.)
YES [ ] NO [ ]

_____

Signature of Applicant or Responsible Party Date

Remainder of page to be completed by local agency

VERIFICATION (*Circle and document at least one*):

Resident Verification

Driver's License _____ Rent Receipt _____

Utility Bill _____ Other _____

Rent/Lease Agreement _____

BENEFITS APPROVAL:

Benefits Approved For (*List names*):

_____

_____

_____

_____

CERTIFICATION:

Certification Period _____
(Not to exceed 6 months)

Denied _____ Reason_____

Pending _____ Reason_____

Termination _____ Reason_____
(Copy of Termination Letter Attached)

I hereby certify that this assessment was made on the basis of information contained within the files of our agency. All eligibility criteria were applied as defined by the State of Nevada, Department of Agriculture, Food & Nutrition Division.

_____

Approving Authority (Certifier) Agency Date

RE-CERTIFICATION: (each re-certification is not to exceed six months.)

Re-certification Period From: _____ To: _____ Certifier's Initials: ____ Date: _____	Re-certification Period From: _____ To: _____ Certifier's Initials: ____ Date: _____	Re-certification Period From: _____ To: _____ Certifier's Initials: ____ Date: _____	Re-certification Period From: _____ To: _____ Certifier's Initials: ____ Date: _____	Re-certification Period From: _____ To: _____ Certifier's Initials: ____ Date: _____